CONSENT FOR CHILD'S MEDICAL/EMERGENCY TREATMENT AND MEDICAL INFORMATION

NAME _____ MOTHER ____ FATHER ____ LEGAL GUARDIAN ____

FOR: CHILD #1 _____ SON ____ DAUGHTER ____ DOB: _____

CHILD #2 _____ SON ____ DAUGHTER ____ DOB: _____

CHILD #3 _____ SON ____ DAUGHTER ____ DOB: _____

CHILD #4 _____ SON ____ DAUGHTER ____ DOB: _____

In presenting my son/daughter for diagnosis and treatment or vaccinations, I hereby voluntarily consent to the rendering of such care including diagnostic procedures, by authorized staff of Belkys Bravo, M.D. P.A. or their designees, as may, in their professional judgment, be necessary in my absence.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

I/WE hereby give my/our consent to:

1. _____ Name of Person: _____
2. _____ Name of Person: _____
3. _____ Name of Person: _____
4. _____ Name of Person: _____

Who may bring my child to Belkys Bravo M.D.P.A. for medical attention as described above.

I/WE acknowledge that I/WE are responsible for all reasonable charges in connection with care and treatment rendered during this period. **ANY COPAYMENT AND/OR DEDUCTIBLES WILL STILL NEED TO BE PAID BY THE PERSON BRINGING THE CHILD TO THE OFFICE AT TIME OF VISIT.**

In case of emergency, I can be reached at: _____

Signature: _____ SS# _____

Date: _____

Please list any allergies:

_____

_____

_____